



TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does this person have significant TB symptoms? Significant symptoms include <u>cough for 3 weeks or more</u>, PLUS least one of the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Coughing up blood</td> <td style="width: 33%;"><input type="checkbox"/> Fever</td> <td style="width: 33%;"><input type="checkbox"/> Night sweats</td> </tr> <tr> <td><input type="checkbox"/> Unexplained weight loss</td> <td><input type="checkbox"/> Unusual weakness</td> <td><input type="checkbox"/> Fatigue</td> </tr> </table>	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue
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<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue					

2. Check for TB Risk Factors

- If any “Yes” box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked “No”, then TB clearance can be issued without testing

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Was this person born in a country with a high TB case rate (refer to TB Document J)? (eg. Not born in the United States, Canada, Australia, New Zealand, Western Europe, Northern Europe, or Japan.)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has this person traveled to (or lived in) a country with a high TB case rate for four weeks or longer?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>At any time has this person been in contact with someone with <i>infectious TB disease</i>? (Do not check “Yes” if exposed only to someone with latent TB)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does this person have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system? <i>Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist (e.g. Humira, Enbrel, Remicade), or steroid medication for a month or longer.</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>For children under age 16: Someone born in a country with a high TB case rate (eg. Not born in the United States, Canada, Australia, New Zealand, Western Europe, Northern Europe, or Japan) is living or has lived in the same household.</p>

Provider Name with Licensure/Degree:	Person's Name and DOB:
Assessment Date:	Name and Relationship of Person Providing Information (if not the above-named person):